ICD-10
International Classification of Diseases, Tenth Revision
TRAINING & COMMUNICATION NEWSFLASH
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Clinical Documentation Improvement (CDI): Moving Forward!

Recent news in ICD-10 has heavily focused on the impacts of the ICD-10 delay and recommended actions moving forward. As the industry works to navigate the delay and establish a firm implementation date, one thing is certain: The delay provides some breathing room to focus efforts on strategic imperatives, including Clinical Documentation Improvement (CDI) efforts. Ensuring documentation meets the level of specificity and granularity necessary for the new robust code set will be a major driving force in successful ICD-10 implementation. The additional time provides further opportunity to evaluate clinical documentation pain points, establish goals, and deliver quality improvement.

Industry CDI Pain Points

Currently, the industry currently recognizes several key pain points associated with CDI and the new structure of the ICD-10 code set:

- Accuracy of Diagnosis: Many complex concepts, such as manifestation, etiology/causation, and lateralization and localization are newly captured in the ICD-10 codes and require an increased specificity and understanding by providers. Quality documentation will appropriately capture those new concepts to reduce documenting the diagnosis inaccurately.
- Completeness of documentation: ICD-10 takes into account more variables than the current code set and it is imperative that documentation satisfy all variables to be successful.
- Queries and Clarifications: ICD-10 will require an increase in coordination between coders and providers, increasing queries, and decreasing productivity for a duration of time. Detailed documentation may reduce the need for clarifications and reduce the loss in productivity.

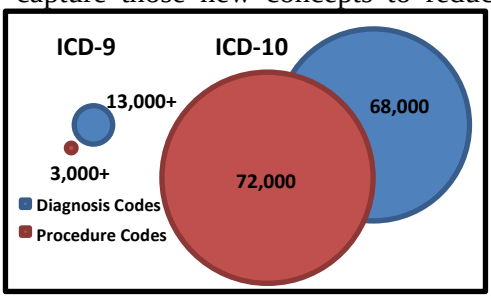

Figure 1 Increase in Number of Codes from ICD-9 to ICD-10 Total number of codes with increase from 16,000 in ICD-9 to 140,000+ in ICD-10. [1]

It is imperative that providers and coders alike recognize the ICD-10 pain points and potential downstream affects for each Medical Treatment Facility (MTF) and the Military Health System (MHS) at large. A strong CDI Program is critical to relieving those pain points and reducing the ICD-10 implementation impact.[2]

The Services Approach to ICD-10

MHS system readiness is on track for completion prior to a possible ICD-10 compliance date, allowing time to ensure each MTF will have quality documentation. This Newsflash highlights the CDI activities of the Services:

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Days Remaining to ICD-10 Conversion
As of 5/1/2014

Upcoming Events

2014 Annual Clinical Coding Meeting
June 6-7, 2014
New Orleans, LA
http://www.wynjade.com/ahimacoding14/

AHIMA Academy for ICD-10-CM/PCS: Building Expert Trainers in Diagnosis and Procedure Coding
July 10-12, 2014
Denver, CO
https://www.ahimastore.org/ProductDetailMeeting.aspx?ProductID=17144

ICD-10 Documentation Training for Physicians
3-hour online course offered by medical specialty
http://www.aapc.com/ICD-10/ICD-10-physician-documentation.aspx

[1] "ICD-10 Implementation Guide for Small and Medium Practices." Centers for Medicare and Medicaid Services, n.d. Web.
[2] Bresnick, Jennifer. "Top ICD-10 Clinical Documentation Improvement Pain Points."*EHRintelligencecom*. N.p., 6 Jan. 2014. Web. 14 Mar. 2014.

Army

The Army is focusing their efforts on ICD-10 coding education and training and improving provider clinical documentation. Army recognizes how important provider clinical documentation is in relation to ICD-10 specific code requirements and will consider developing a CDI Program in the near future.

Navy

In preparing Navy Medicine for the transition to the ICD-10 code set, Navy's Bureau of Medicine & Surgery (BUMED) M3 Health Information Management (HIM) identified areas of improvement within clinical documentation; specifically focusing on processes, policies, and technologies. The goal of Navy Medicine's CDI Program is to improve the accuracy, clarity, and specificity of provider documentation to achieve complete and accurate code assignment for the reporting of diagnoses and procedures as required by ICD-10. M3 HIM developed a CDI Program Framework to provide the structure for a CDI Program at each MTF. The CDI Program Framework has six (6) key elements: Goals, Roles and Responsibilities, Tools and Forms, Metrics-Monitoring-Reporting, Communication, and Prioritized Opportunities. To support MTF implementation of the framework, M3 HIM developed a CDI Program Manual that provides standardized steps to help MTFs develop, execute, and advance their CDI Programs.

Air Force

The Air Force Medical Operations Agency (AFMOA) in conjunction with facility Case Managers, Discharge Planners, Coding Liaison Managers (CLMs), and Inpatient Coders coordinated an Inpatient CDI Program. The CDI program establishes a working relationship among GS Coders and Nursing SMEs. The CDI Program's plan is for ALL parties to work diligently to enhance communication and clinical documentation, with ultimately improving patient care. Goals/Expectations of the program include to:

- Promote support from all constituencies
- Allocate and ensure access to organizational resources
- Monitor overall performance and communicate results to constituents to promote support
- Provide ongoing management support in resolving issues affecting implementation and performance of CDI.

As the CDI Program evolves, the meeting frequency will be established. Communication Tools will include, but not be limited to utilization of Physician Query Process, CDI alerts, and ICD-10 alerts. CDI protocols include utilization of AFMOA audit results to further train and educate ALL CDI team members. CDI information will be posted on the KX ICD-10 website, https://kx2.afms.mil/kj/kx4/ICD10.

Moving Forward: Industry Focus on Education, Efficiency and Proficiency

In the industry overall, there is a big push to focus on education. Many are finding success through integrated education, where educational sessions involve documentation specialist and coders providing support to providers while completing education imbedded in current ICD-9 CDI Programs. This helps educate providers from a clinical perspective, instead of a coding perspective. It also gives documentation specialists the opportunity to see the clinical threshold for particular diagnoses, what specificity is required, and let them actually interact with providers in a concurrent fashion or real-time with technology. In a recent article in "EHRIntelligence," Ms. Mel Tully, MSN, CCDS, CDIP, Senior Vice President of Clinical Services and Education at Nuance, notes they are advising clients to identify their top 20 DRG codes for medical diagnoses, as well as procedural diagnoses and ensure they are very efficient, very proficient, and understand exactly the clarifications and the clinical documentation that is needed for those particular top diagnoses and procedures in ICD-10.[3]

The Golden Rule:
If it is not documented by the provider, it cannot be coded or billed.

For more information, please contact: HIPAATCSImail@dha.mil

[3] Bresnick, Jennifer. "ICD-10 Education Must Focus on Clinical Documentation Improvement." *EHRintelligencecom*. N.p., 30 Jan. 2014. Web. 14 Mar. 2014.